MEDICAID MANAGED CARE ADVISORY COMMITTEE MEETING
JUNE 17, 2020

Department of Medical Assistance Services

Virtual Meeting Notice

DMAS is conducting this meeting electronically via Webex due to the declared emergency related to the COVID-19 pandemic.

Committee Members – Roll Call

Agency	Name
Department of Behavioral Health & Developmental Services	Commissioner Land
VA Association of Centers for Independent Living	Gayl Brunk
Virginia Hospital and Health Care Association	Chris Bailey
Medical Society of Virginia	Clark Barrineau
VA Association of Community Services Boards	Jennifer Faison
DARS/Ombudsman	Kathy Miller
VA Poverty Law Center	Sara Cariano
Virginia Association for Home Care and Hospice	Marcia Tetterton
Virginia Health Care Association	Steve Ford
Virginia Academy of Family Physicians	Hunter Jamerson

Committee Members – Roll Call

Agency	Name
Lake Country Area Agency on Aging	Gwen Hinzman
American Academy of Pediatrics	Samuel Bartle, MD
Virginia Association of Health Plans	Doug Gray
Virginia Community Healthcare Association	Neal Graham
Virginia Healthcare Foundation	Debbie Oswalt
National Alliance for Mental Illness - VA	Kathy Harkey
Virginia Interagency Coordinating Council	Kelly Walsh-Hill
Behavioral Health Organizations (rotate) VCOPPA for 2020	Bill Ellwood
Association of Free Clinics	Rufus Phillips
Department of Social Services	Commissioner Storen
Virginia Department of Health	Laurie Forlano, DO

Committee Members – Roll Call

Agency	Name
Department of Health Professions	David Brown
American College of Obstetricians and Gynecologists	Holly Puritz, MD
Board for People with Disabilities	Nia Harrison
BMAS Member	Raziuddin Ali, MD
PACE Alliance	George Graham

Questions: Q and A box

Committee members – please type questions into the Q and A box. These questions will be answered by the presenter after each agenda item.

Members of the public – we will take questions from the public at the end of the meeting as time allows. Please hold your questions.

Agenda

- Director's Welcome
- Finance and Technology Update
- Medicaid and COVID-19: Empowering Patients and Providers to Address the Crisis
- Policy and Administration Update
- COVID-19 Flexibilities: Long-Term Services and Supports
- Non-COVID Managed Care Programs Update
- Public Comment

WELCOME

Karen Kimsey, Director

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

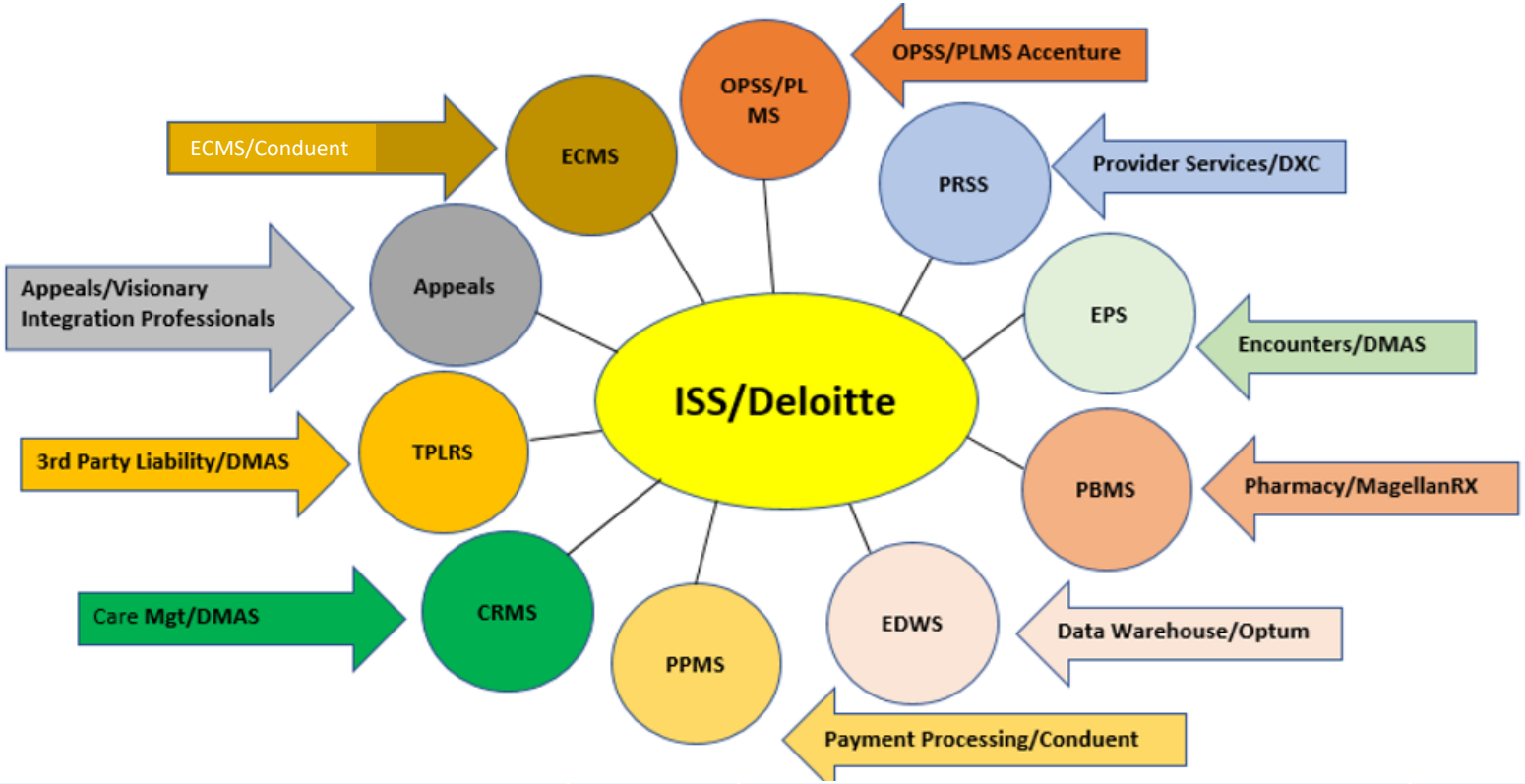
FINANCE & TECHNOLOGY UPDATE

Presentation to:

Medicaid Managed Care Advisory Committee

June 17, 2020

Medicaid Enterprise System (MES) Timeline



Enterprise Data Warehouse (EDWS)	Live	Enterprise Content Management System(ECMS)	Aug 2020
Encounter Processing Services (EPS)	Live	Provider Services Solution (PRSS)	Sep. 2020
Pharmacy Benefit Management Solution (PBMS)	Live	Care Management Solution (CRMS)	July 2020
Third Party Liability Systems (TPLRS)	Live	Operations Services Solution & Plan Management (OPSS/PLMS)	Negotiations
Integration Services Solution (ISS)	July 2020	Payment Process Management Solution (PPMS)	Negotiations
Provider Appeals	Sep 2020		

Conduent MMIS Contract

CONDUENT

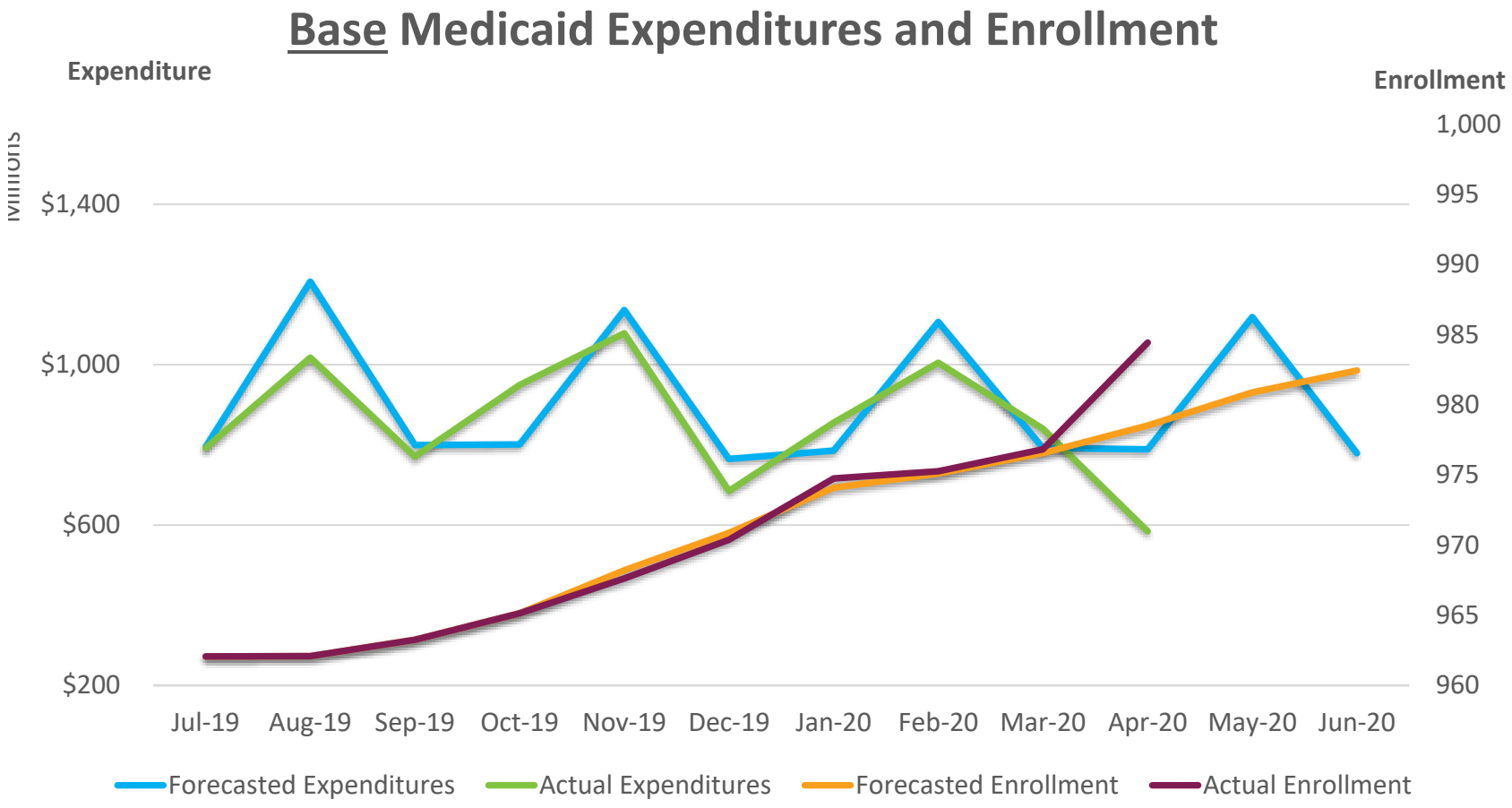
Late March

Contract negotiations

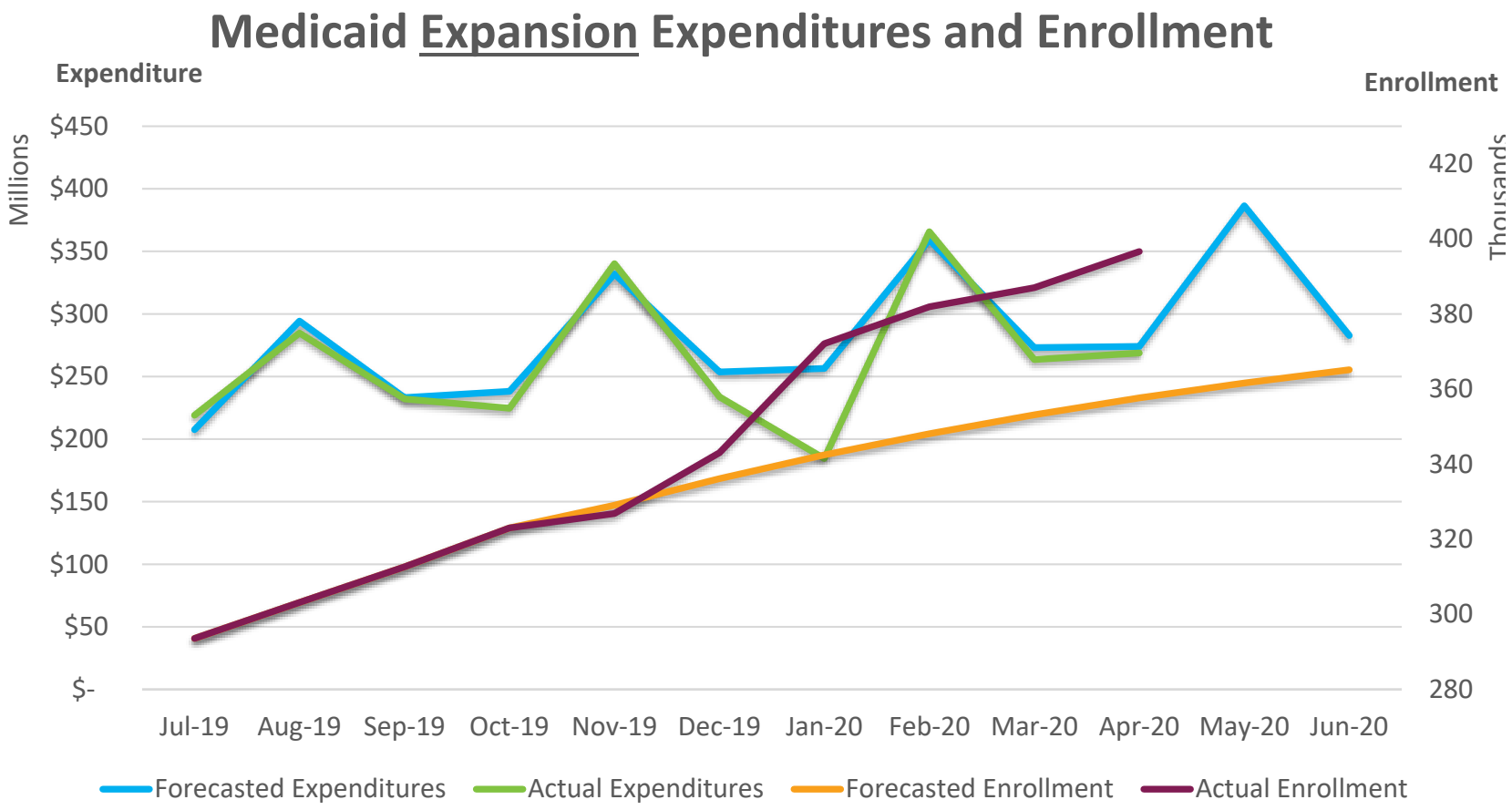
May1

Submitted Contract to CMS, OAG, and VITA

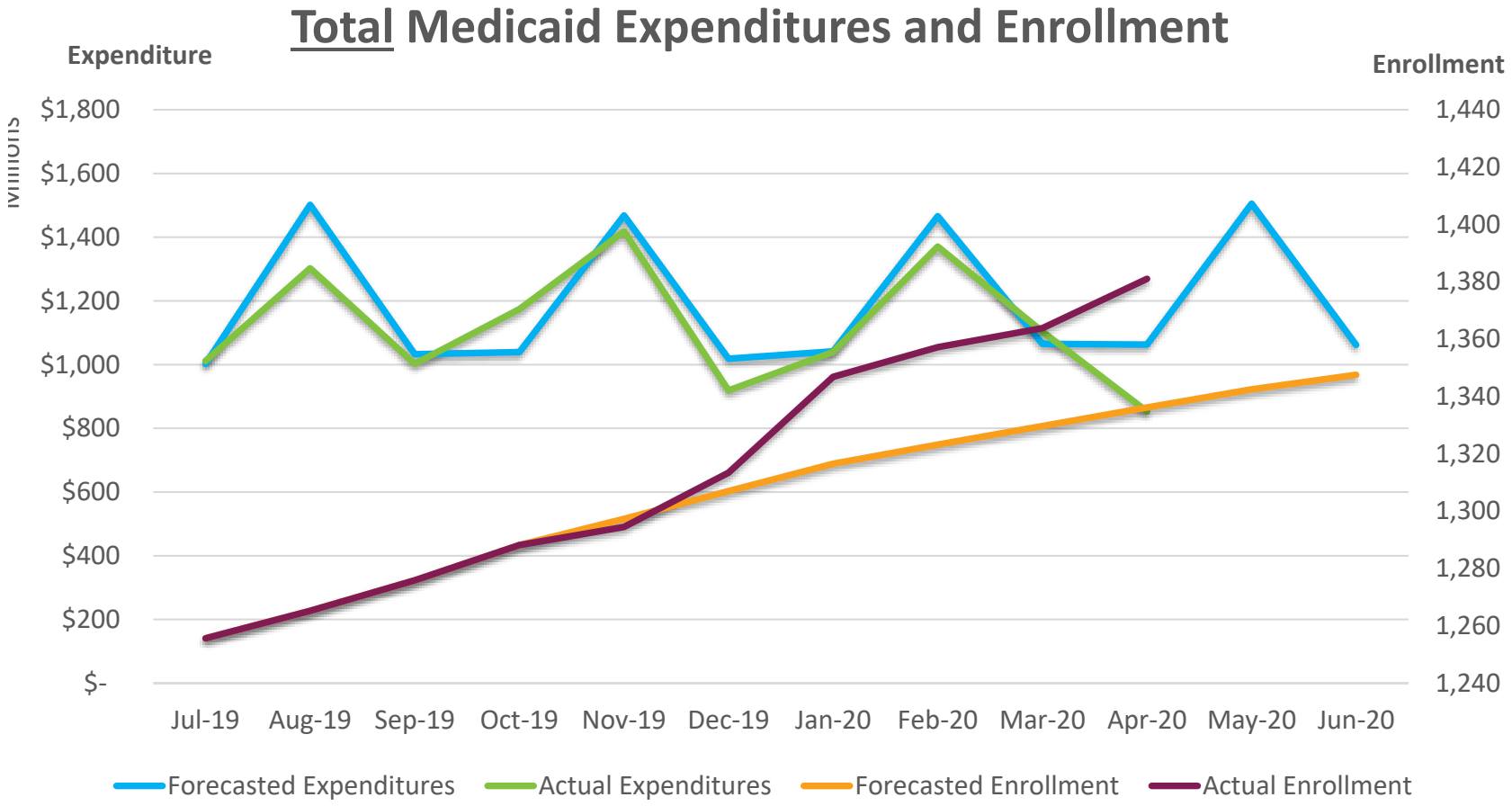
DMAS Forecast vs. Actuals – FY20



DMAS Forecast vs. Actuals – FY20



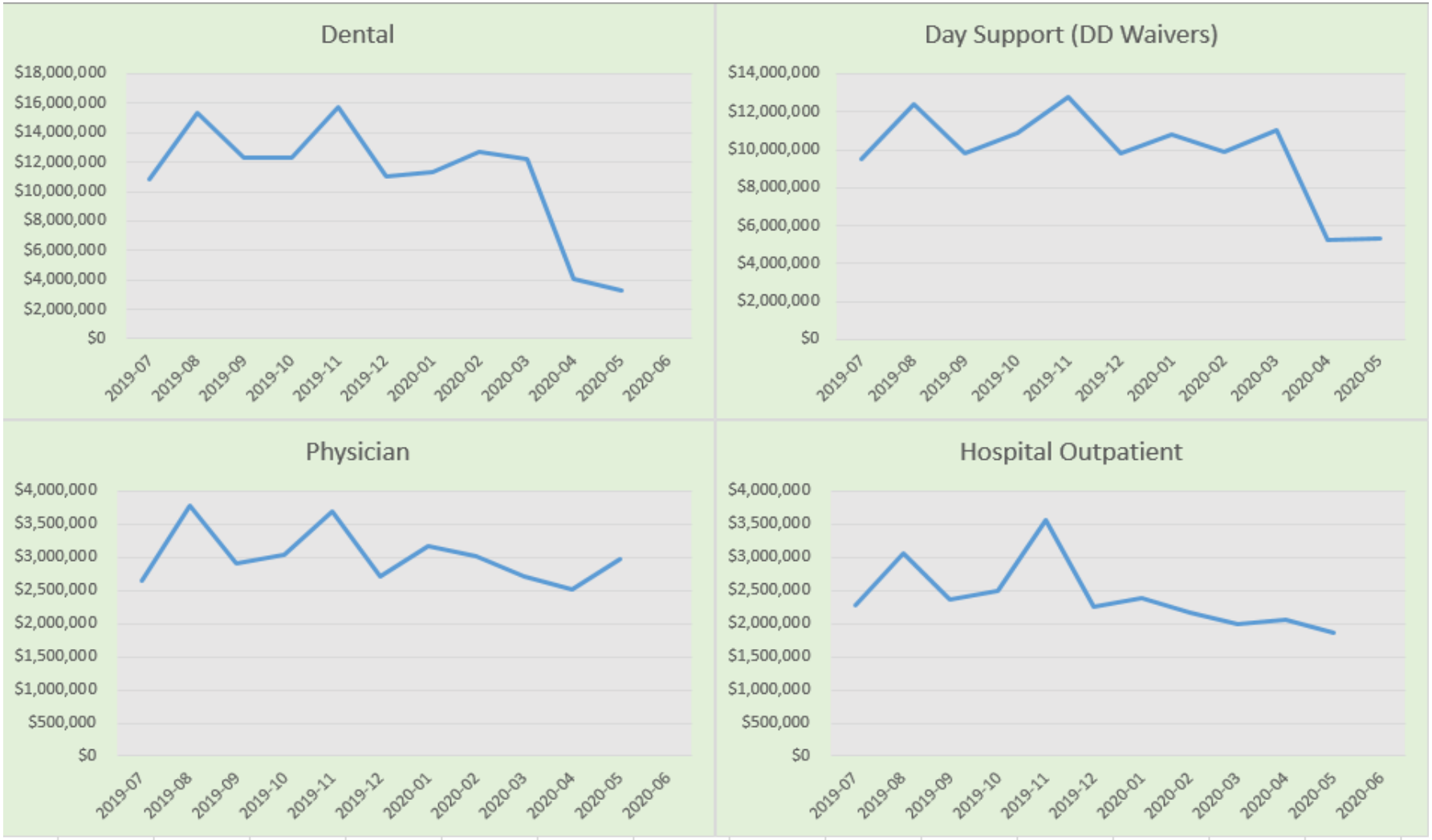
DMAS Forecast vs. Actuals – FY20



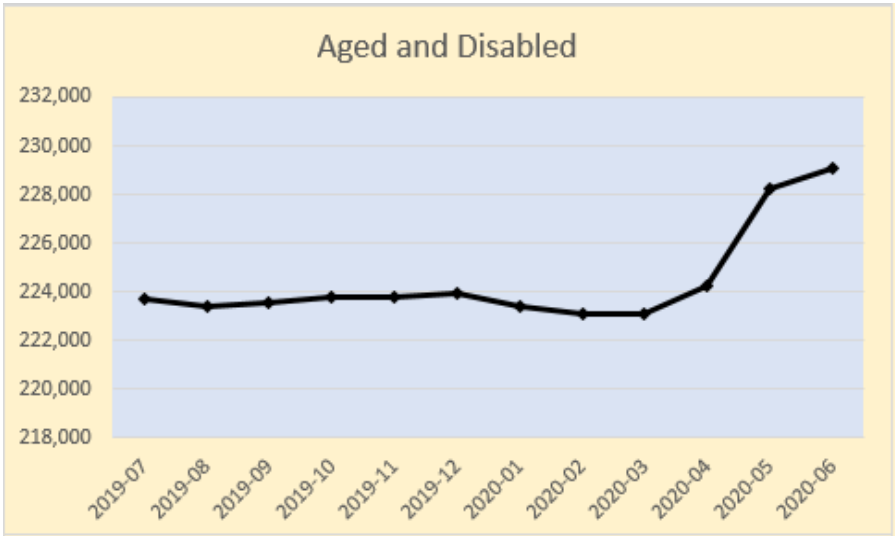
DMAS Administrative Expenditures – FY20

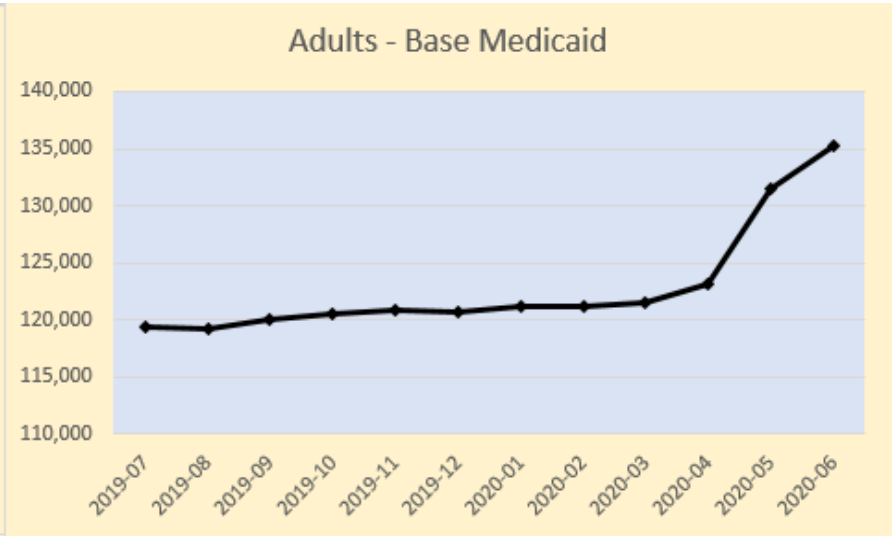
SFY20 ADMIN YE PROJECTIONS			
	GF Budget	YE GF Projections	Remaining GF Balance
Agency Operations	1,956,905	2,427,999	(471,094)
Contractual Services	28,076,566	26,857,373	1,219,193
Information Technology	14,106,501	11,373,767	2,732,734
Professional Development	431,393	341,909	89,484
Salaries & Benefits	21,376,717	21,223,968	152,749
TOTAL	$65,948,082	$62,225,016	$3,723,066
GF Pledge	($3,500,000)		($3,500,000)
TOTAL APPROPRIATION	$62,448,082	$62,225,016	$223,066

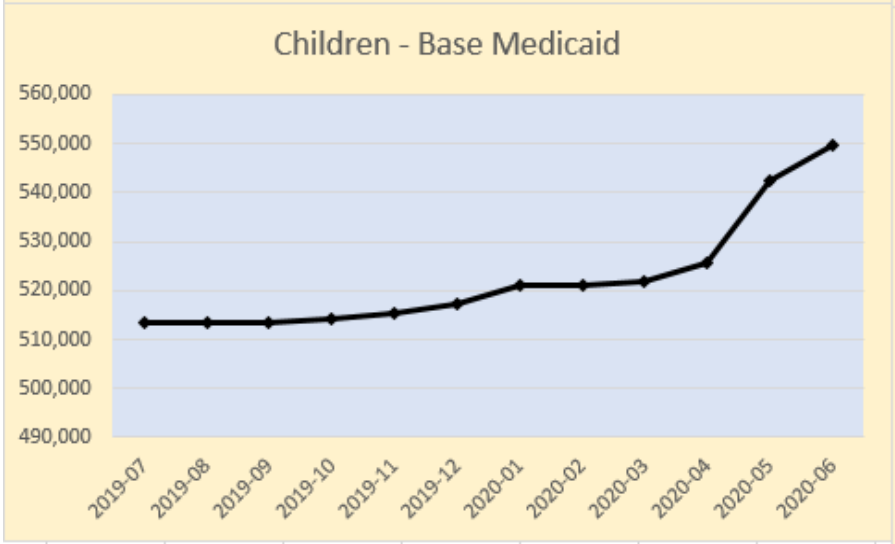
DMAS Medical FFS Expenditures-COVID19

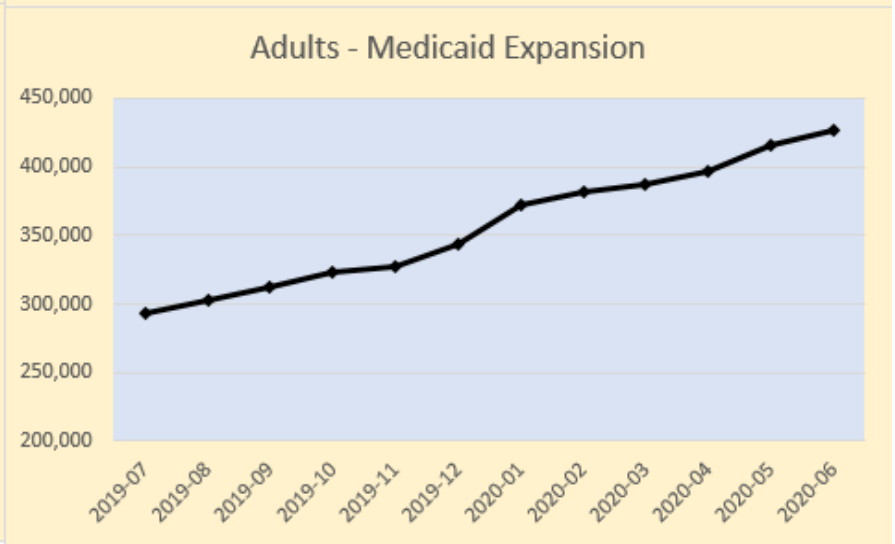


DMAS Medical Enrollment-COVID19

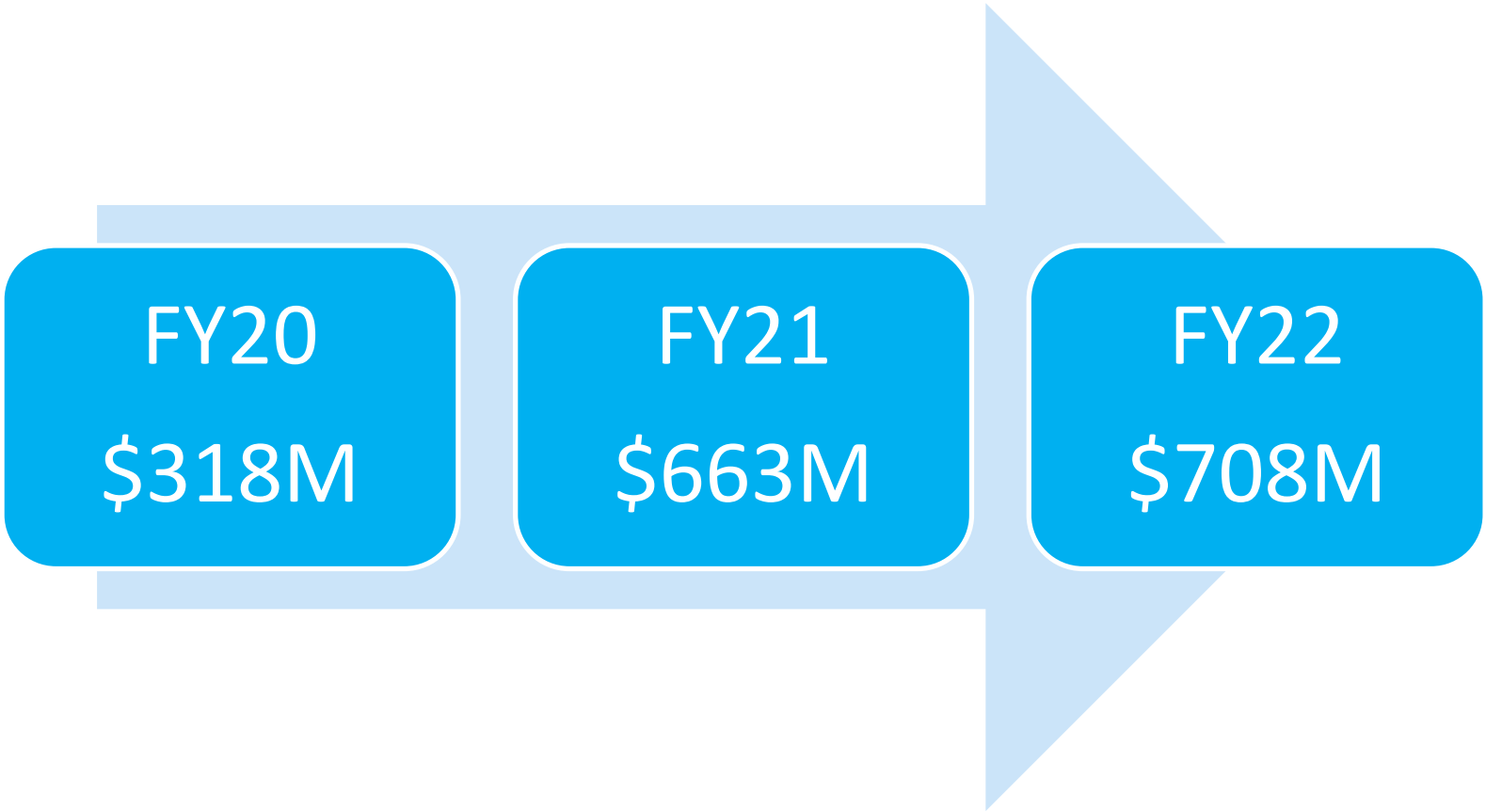








DMAS EFMAP-COVID19



DMAS FY20 Agency Year End Balances

PROGRAM	SFY2020 General Fund Appropriation	Projected Year End Balance*
Temporary Detention Orders	$17,991,740	$663,588
Family Access to Medical Insurance Security Plan (FAMIS)	$33,417,135 $14,065,627 (FAMIS Trust Fund)	$333,687 $0
Medical Assistance for Low Income Children (MCHIP)	$41,382,173	$7,208
Non-Medicaid Medical Assistance Services (HIV and UMCF)	$781,702	$335,425
Medicaid	$4,765,424,364 $408,419,831 (VHCF)	$83,715,021 $0
Medicaid & CHIP Forecasted Admin	$14,377,806	$2,435,706
Administrative and Support Services	$66,735,862	$223,066

**Projected balances includes the EFMAP unallotment and DMAS' general fund year end pledge*

Capitation Rate-Setting

Milestone in FY21 Capitation Rate Setting	Date
Send Draft Rates to MCOs.	**4/1/2020**
Initial FY21 Medallion and CCC Plus Rate Meeting with MCOs	4/8/2020
Host Q and A session with MCOs/CFOs	**5/8/2020**
Finalize and Send Interim Rates to MCOs	5/13/2020
Interim Final FY21 Rate Meeting.	**5/22/2020**
Finalize FY21 Rates, Notify DPB and Money Committees.	6/1/2020
Submit contract and rates to CMS for approval.	**6/19/2020**

Provider Health Information Breach Notification

March 2, 2020

Notify Internal Stakeholders:

- DSS
- CoverVA
- Others

March 5, 2020

Notify MCOs:

- Anthem
- Aetna
- Magellan
- Optima
- Virginia Premier
- United Healthcare

March 9, 2020

Notify Members:

- 6,120 members affected

March 26, 2020

Notify the Public:

- Posting in daily newspapers
- Website updated

Credit monitoring was provided to all affected members through Symantec Lifelock. DMAS established a call center to take member questions on the breach.

APPENDIX
HB30 FY21/22 Unallotted Items

Item Description (Includes Admin and Medical)	FY2021	FY2022
Supplemental Payments for Children's National Medical Centers	($354,766)	($354,766)
Fund Managed Care Contract Changes	($812,600)	($1,014,350)
Increase Medicaid Rates for Anesthesiologists	($253,376)	($262,491)
Increase payment rate by 9.5% for Nursing Homes with special population	($493,097)	($506,903)
Increase mental health provider rates	($2,374,698)	($2,458,479)
Add 500 DD Waiver Slots in FY 2022	$0	($4,133,500)
Modify Nursing Facility Operating Rates at Four Facilities	($733,303)	($754,247)
Modify Medicaid Nursing Facility Reimbursement	($6,794,541)	($6,984,788)
Increase DD waiver provider rates using updated data	($21,395,221)	($22,037,077)
Increase Developmental Disability (DD) waiver rates	($3,639,663)	($3,748,853)
Increase Rates for Skilled and Private Duty Nursing Services	($6,245,286)	($6,245,286)
Provide care coordination prior to release from incarceration*	($252,104)	($369,741)
Residential Psychiatric Facility Rates	($7,599,696)	($7,599,696)

APPENDIX
HB30 FY21/22 Unallotted Items Continued

	FY2021	FY2022
Add Adult Dental Benefit to Medicaid	($8,743,420)	($25,304,935)
Allow Overtime for Personal Care Attendants	($9,609,223)	($9,609,223)
Expand opioid treatment services	($421,476)	($1,273,633)
Medicaid MCO Reimbursement for Durable Medical Equipment	($345,621)	($352,534)
Modify Capital Reimbursement for Certain Nursing Facilities	($119,955)	($119,955)
Allow FAMIS MOMS to access substance use disorder treatment in an institution for mental disease	($307,500)	($356,775)
Fund home visiting services	$0	($11,750,159)
Fund costs of Medicaid-reimbursable STEP-VA services	($486,951)	($2,293,826)
Extend FAMIS MOMS' postpartum coverage to 12 months	($1,114,936)	($2,116,376)
Enhance behavioral health services	($3,028,038)	($369,741)
Medicaid Works for Individuals with Disabilities	($114,419)	($7,599,696)
Expand Tobacco Cessation Coverage in Medicaid	($34,718)	($25,304,935)
Fully Fund Medicaid Graduate Medical Residency Slots	($1,350,000)	($9,609,223)

APPENDIX
HB30 FY21/22 Unallotted Items Continued

	FY2021 GF	FY2022 GF
Increase Rates for Adult Day Health Care	($796,755)	($1,273,633)
Eliminate 40 quarter work requirement for legal permanent residents (medical costs)	($1,002,169)	($352,534)
Eliminate 40 quarter work requirement for legal permanent residents (admin costs)	($169,922)	($94,667)
Provide care coordination prior to release from incarceration	($95,699)	($95,699)
Medicaid Provider Rates Analysis	($300,000)	
Administrative Costs to Implement Live-In Caretaker Exemption	($507,500)	($373,000)
Total Unallotted Items	**($78,539,655)**	**($127,501,107)**

Questions from committee members?





MEDICAID AND COVID-19: EMPOWERING PATIENTS AND PROVIDERS TO ADDRESS THE CRISIS

June 17, 2020

CHETHAN BACHIREDDY, MD, MSC

CHIEF MEDICAL OFFICER, DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Agenda

The Crisis

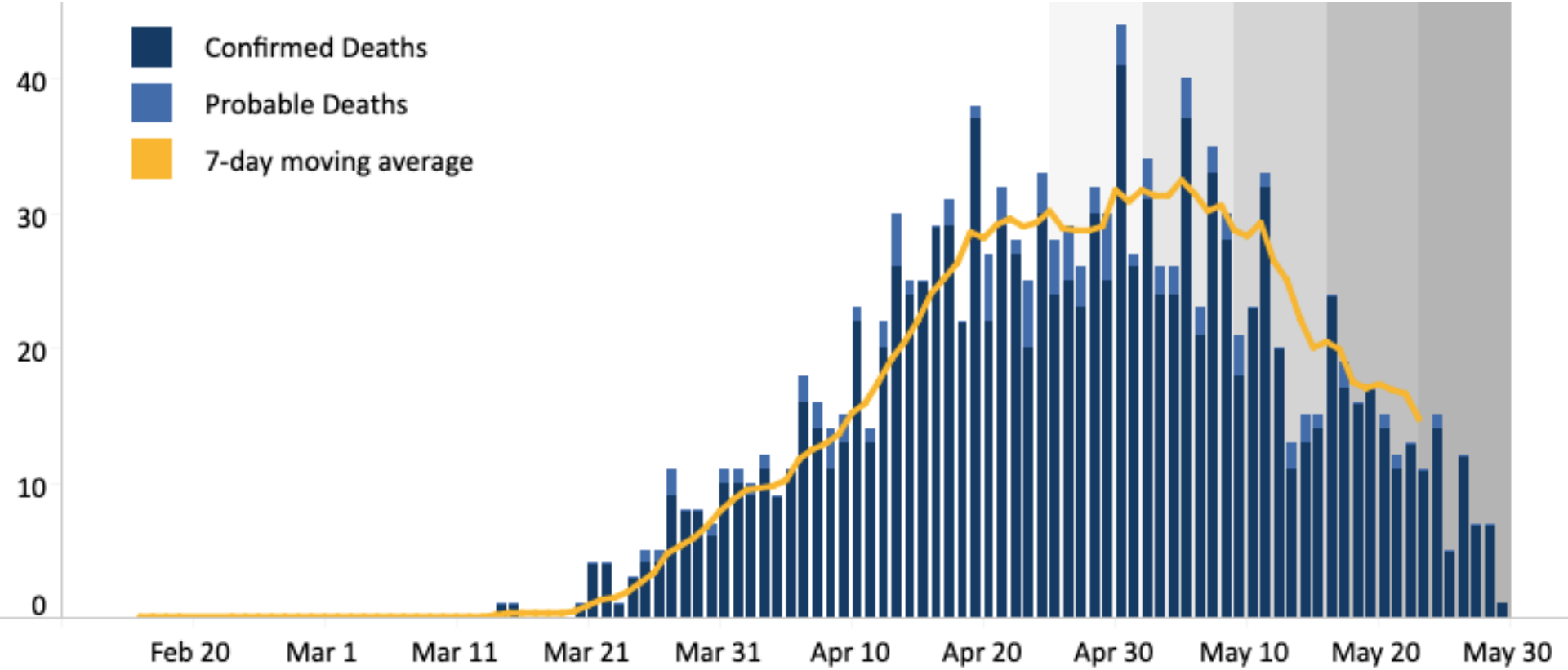
Testing

COVID Check

Telehealth

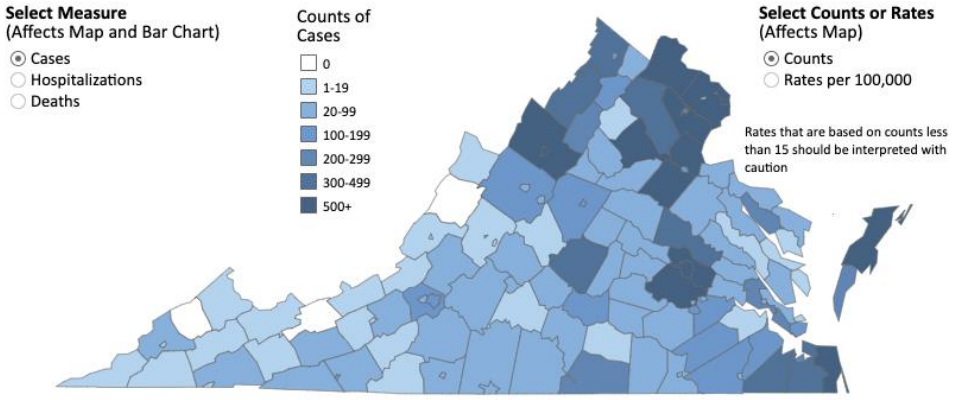
The COVID-19 Crisis

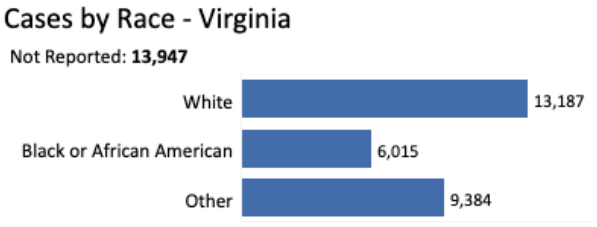
Total Cases*	Total Hospitalizations**	Total Deaths
43,611	4,601	1,370

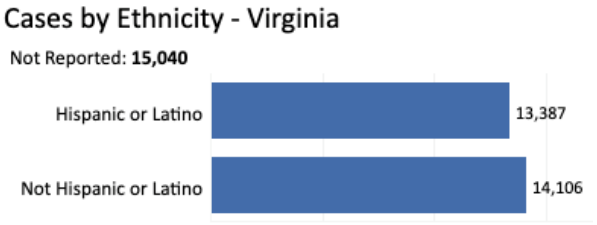


Source: VDH

Who is Impacted by COVID-19?



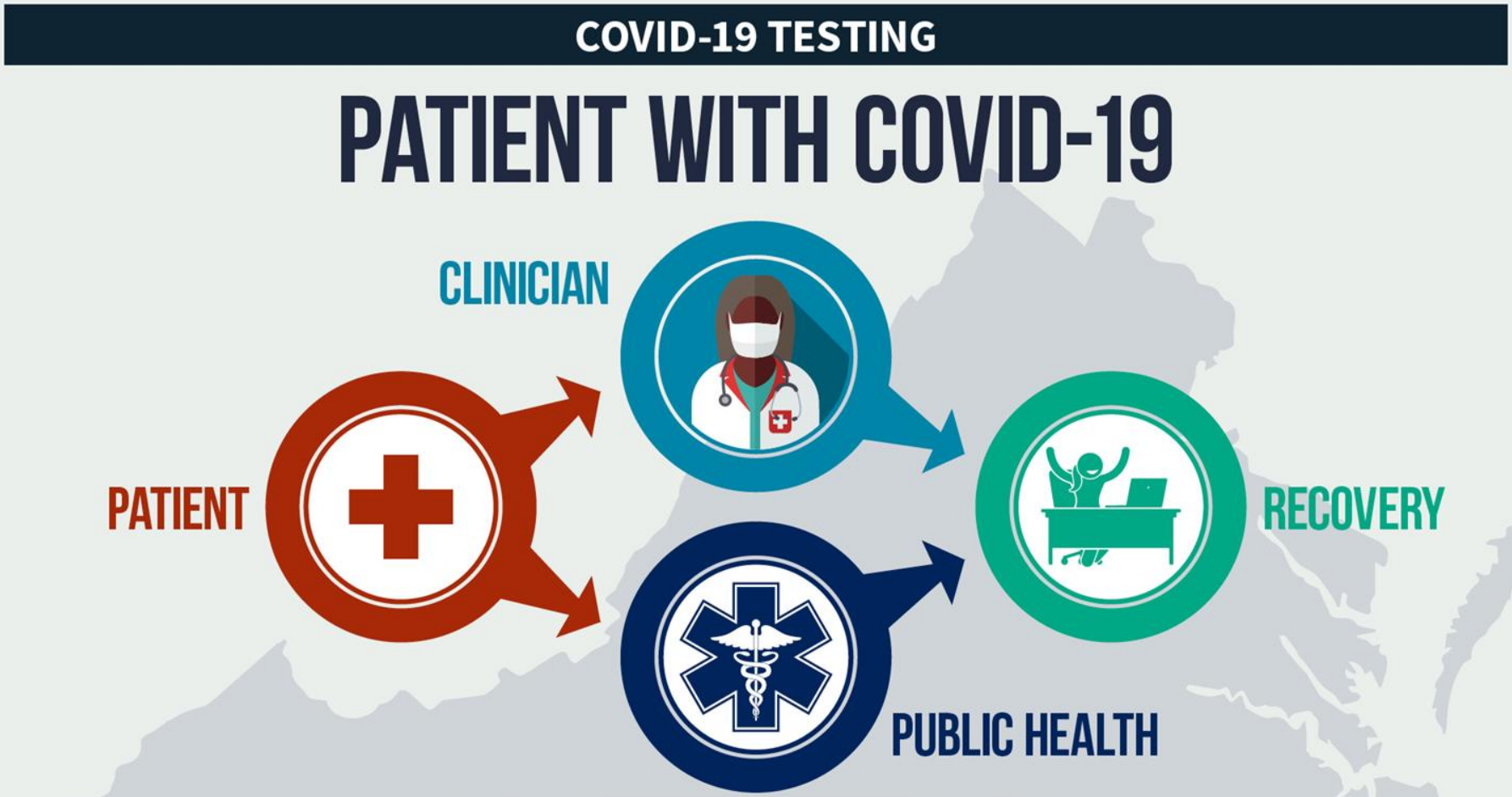




Cases and Deaths by Outbreak Facility Type - State Totals

Long Term Care Facilities	Cases	4,757
	Deaths	774
Congregate Setting	Cases	1,501
	Deaths	21
Correctional Facility	Cases	1,208
	Deaths	5
Healthcare Setting	Cases	111
	Deaths	4
Educational Setting	Cases	46
	Deaths	0

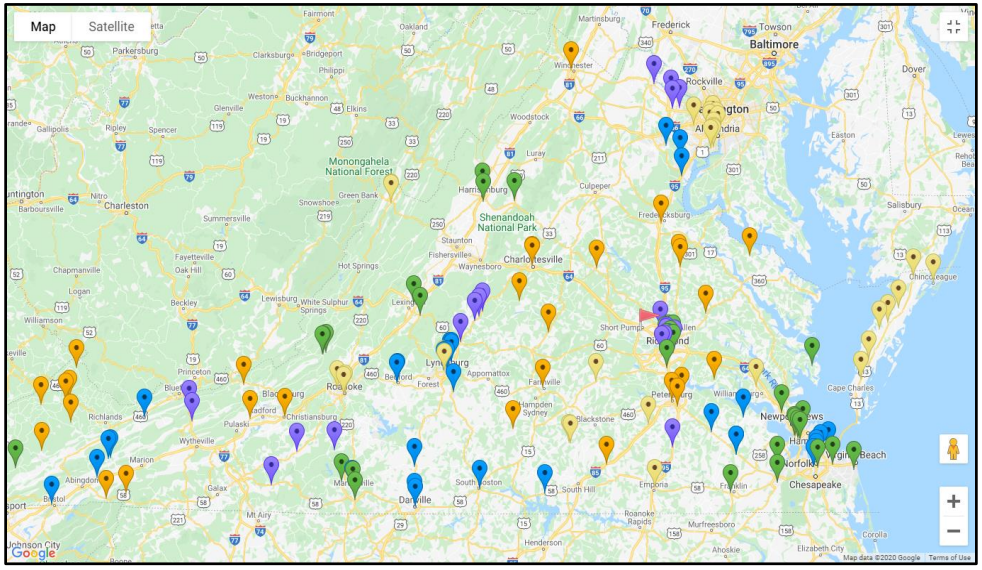
Testing


COVID-19 TESTING
PATIENT WITH COVID-19
CLINICIAN
PATIENT
RECOVERY
PUBLIC HEALTH

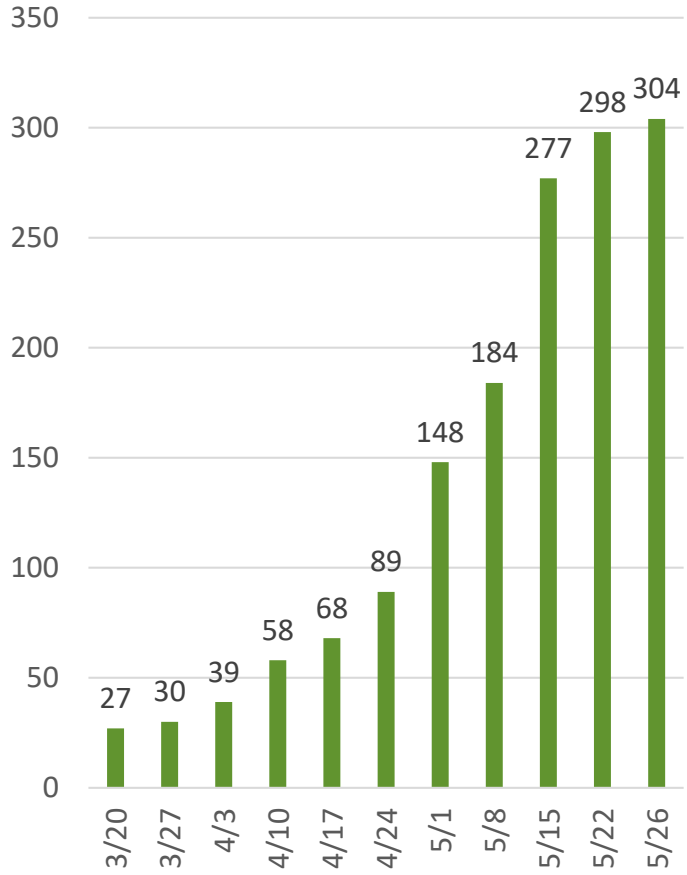
Activating Providers to Expand Testing

May 27, 2020:

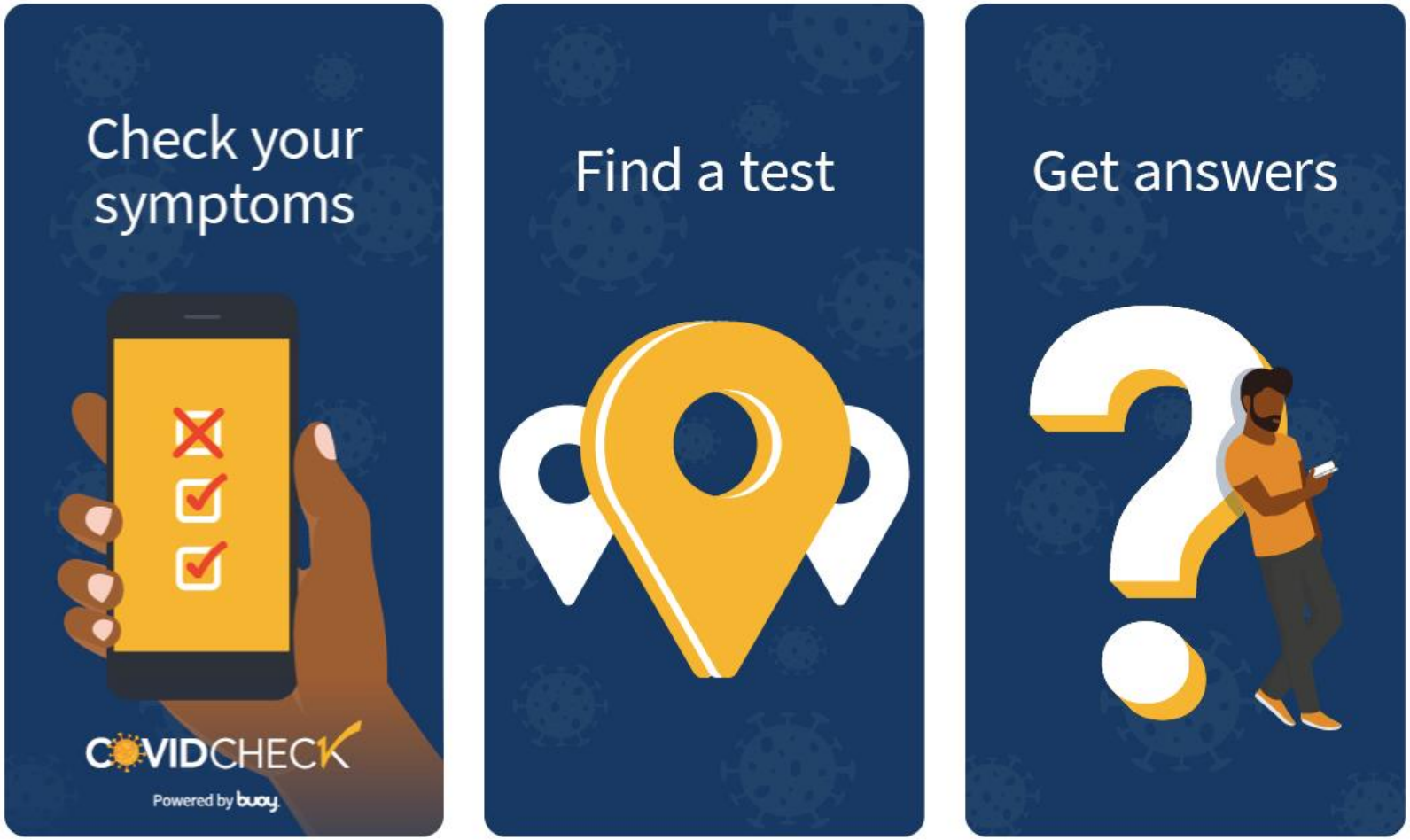
- Partnership with Virginia Community Healthcare Association.
- **31** FQHCs currently offering testing, with an additional **37** under consideration.



Public Testing Sites



Activating Members through COVID Check



COVID Check

Self-assessment → Guidance → Navigation → Care

This tool is not a substitute for professional medical advice, diagnosis, or treatment. If you are experiencing a life-threatening emergency that requires immediate attention please call 911 or the number for your local emergency service.

Let's assess your risk for coronavirus

Are you experiencing any of the following symptoms?

Please mark all that apply

- Chills
- Cough
- Fever
- Difficulty getting enough air

Contact a medical professional today

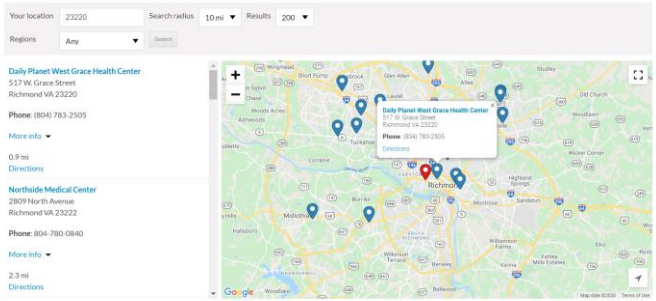
Because of your chills and pre-existing medical condition, it is possible that you have coronavirus.

We recommend contacting a medical professional today.

Expect longer-than-average wait times and limited supply of tests in most areas.

If this feels like an emergency, visit the nearest emergency room.

COVID-19 Testing Sites



All insurance plans within Virginia are waiving deductibles, copays, and coinsurance for telehealth visits related to coronavirus. If you can't reach your doctor or don't have one, select one of the options below. Contact your health plan to check for coverage before your visit.

VIRTUAL CARE

LiveHealth ONLINE

LiveHealth Online

- 24/7
- Log in to see wait time

Last Updated 5/31 @ 7:59 PM

- ✓ Talk to a doctor about getting a required referral for coronavirus testing.
- ✓ Care for non-emergency illnesses and injuries.
- ✓ Prescriptions may be available as needed.

Connect Now

VIRGINIA'S MEDICAID PROGRAM DMAS

Ensuring Access to Care through Telehealth

- Home as an originating site
- Use of audio in addition to audio-visual modalities
- Payment parity with in-person visits
- Simplified billing and documentation
- Remote patient monitoring for COVID-19
- Enhanced specialty access through eConsults

Questions from committee members?

POLICY & ADMINISTRATION UPDATES

MEDICAID MANAGED CARE ADVISORY COMMITTEE

June 17, 2020

RACHEL PRYOR
DEPUTY DIRECTOR OF ADMINISTRATION

Virginia's COVID-19 Policy Strategy

Since the declaration of the public health emergency, DMAS has taken actions to extend flexibilities to support members, providers, and other stakeholders, and mitigate the impact of COVID-19.

- Two Executive Orders issued pertaining to Medicaid
- 86 provisions of state regulation waived
- Six provider memos have been issued
- Nine federal regulatory waivers filed
- COVID-19 landing page added to DMAS and Cover VA websites to include resources for advocates, providers and members

Key Provisions from Congress Related to Medicaid

COVID-Related Resources

- **6.2% FMAP Increase**. Contingent on DMAS meeting the Maintenance of Effort and continuation of coverage requirements per Section 6008 of the Families First Coronavirus Response Act (FFCRA)
- **COVID Relief Fund**. Approximately $3.1 B to Virginia plus $200 M for localities; totaling $3.3 B.
- **Provider Relief Fund.** $175 B (CARES bill) in direct funding to healthcare providers for expenses and lost revenue attributable to COVID-19 and not reimbursable through other sources.
- **Increased health-related spending**. Approximately $180 B in increased health-related spending in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, with much of it aimed directly at providers – unclear how much will go to Virginia and its providers (CRFB).
- **4th stimulus package likely on the way.** Details are unclear; may include additional Medicaid provisions, among other forms of assistance.

Federal Pathways

Authority Type	Description
Concurrence Letter	Allows a state to leverage flexibilities under specific circumstances without a requirement to amend the State Plan. Prior CMS concurrence is not required under regulation, but assists in the event of PERM review or audit.
State Plan Amendment Disaster Relief SPAs	During the emergency, revises eligibility, enrollment, cost sharing & benefit requirements in the State Plan. Requires CMS approval, lasts length of the emergency as declared by Secretary Azar.
Section 1135 Waiver	Authority to temporarily waive certain requirements to ensure sufficient health care items & services are available for emergency needs. Enables providers to furnish needed items & services, be reimbursed & exempted from sanctions. Requires CMS approval, ends at termination of emergency.
Section 1115 Waiver	Waives compliance with certain provisions of federal Medicaid law & authorizes expenditures not otherwise permitted by law. Disaster-related demonstrations can be retroactive to the date of the Secretary's declared public health emergency. Submissions are exempt from normal public notice process in emergent situations. Requires CMS approval.
1915(c) Waiver Appendix K	Submitted during emergency to document necessary changes to waiver operations, includes actions that can be taken under Section 1915(c) in an emergency, goes into effect in the event of a disaster.

Federal Flexibility Pathways

Teams have moved aggressively to assist members and providers during the COVID-19 crisis.

Federal Authority	Date Requested Flexibility to CMS	Current Status
Concurrence Letter	3/16/2020	Approved
Medicaid Disaster Relief State Plan Amendments (SPA)	3/13/2020 (Part I) 5/1/2020 (Part II)	Approved Approved
CHIP Disaster Relief SPA	3/16/2020 (Part I) 4/24/2020 (Part II)	Approved Approved
Section 1135 Waiver Part I	4/15/2020	Approved
Section 1135 Waiver Part II	4/23/3030	Approved
Section 1115 Waiver	5/29/2020	Pending
1915(c) Waiver Appendix K	4/17/2020	Approved

COVID-19: State Flexibility Pathways

Executive Order 51 (issued 3/12) – authorized executive branch agencies to waive any state requirement or regulation, and enter into contracts without regard to normal procedures or formalities

Executive Order 58 (issued 4/23) – waived additional provisions in the Code of Virginia

2020 Appropriations Act (Chapter 1289) Item 317.DD – allows DMAS updates to the State Plan & related waivers to address the pandemic. **HB30, Item 4-5.03 (Services and Clients)** – removed limits on altering & changing cost factors in response to COVID-19 when funding is from a non-general fund source or any source when approved by the Governor in response to the pandemic.

COVID-19 Related Eligibility & Enrollment Changes

Teams moved aggressively to assist members during the COVID-19 crisis.

Continuation of Coverage

- ✓ Delayed acting on changes affecting eligibility
- ✓ Expanded redetermination timelines
- ✓ Continuation of coverage for all Medicaid and CHIP members
- ✓ Waive out-of-pocket costs to member for duration of state emergency.

Additional Member Flexibilities

- ✓ Waive public notice and comment period requirements related to SPAs and modify tribal consultation timeframes.
- ✓ Suspend integration requirement for incarcerated individuals
- ✓ Consider Medicaid beneficiaries displaced from VA temporarily absent
- ✓ Accept attestation of medical expenses

COVID-19 Related Appeals Changes

Member Appeals

For appeals filed during the state of emergency, Medicaid members will automatically keep their coverage (i.e. Medicaid eligibility or an appealed existing medical service) while the appeal is proceeding. Medicaid managed health plans will also approve continued coverage while their internal appeal process is underway.

The timeframe to file an appeal is extended during the period of emergency.

DMAS will hold all hearings by telephone, but if the member is unable to participate at the scheduled time, DMAS will reschedule the hearing to a later date.

Provider Appeals

Providers affected by the COVID-19 emergency can request a hardship exemption to the normal deadline to file an appeal.

All deadlines after an appeal has been filed are extended for the period of the declaration of emergency.

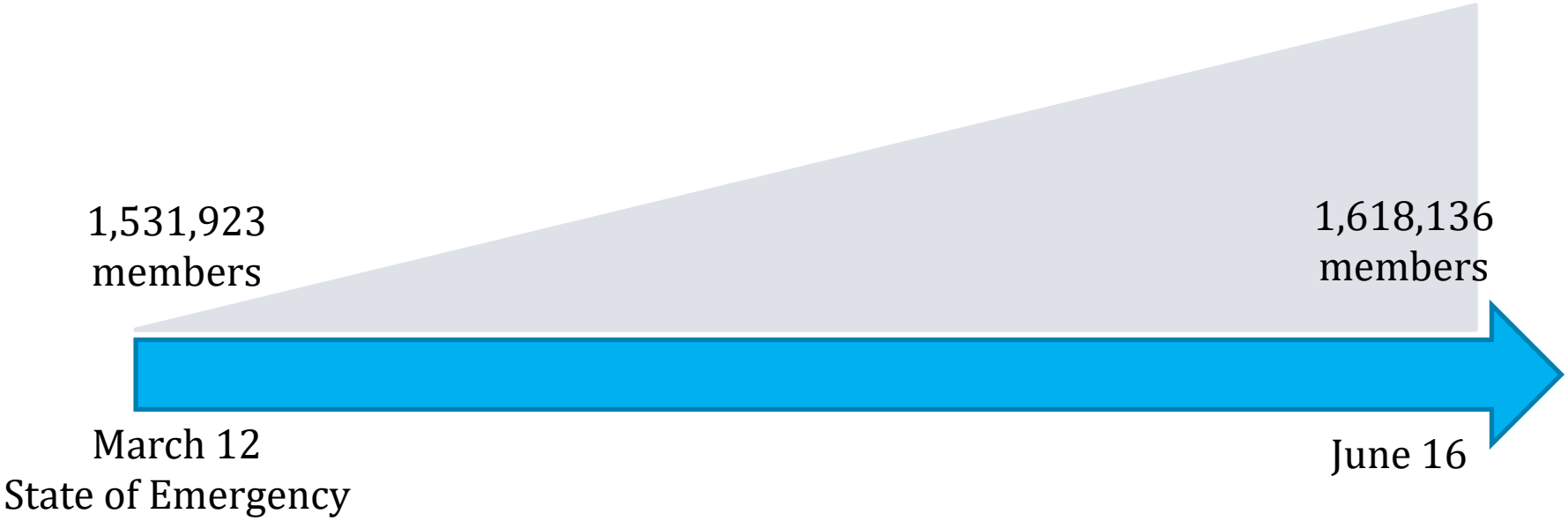
All informal fact-finding conferences and formal hearings will be conducted by telephone during the period of emergency.

Additional Member Improvements

- **Cover Virginia Consumer Inbox** – A new inbox has been added to allow members and applicants to submit verifications that have been requested at application, renewal, or when a change is reported. Created in response to the emergency, this inbox will remain a permanent option for consumers

- **Authorization for Verbal Consent**: allows an individual to grant verbal consent to an application assister such as a navigator or Certified Application Counselor to file an application on the individual's behalf by paper, telephonically, or electronically

Medicaid Enrollment



- Since the State of Emergency was declared, Medicaid has gained **87,199 new members**
  - 38,126 are in Medicaid Expansion
  - 30,452 are children
- On average, Medicaid gains **900 new members each day**

Questions from committee members?

COVID-19 FLEXIBILITIES: LONG-TERM SERVICES AND SUPPORTS

BMAS
June 10, 2020

Tammy Whitlock, Deputy Director of Complex Care and Services

Waiving Service Authorization Requirements on Select Services

Medicaid Memo 3/19/20

- Service authorizations for specific Waiver or EPSDT services automatically extended for 60 days.
- Service authorization requirements for specific DME and Home Health services are waived during the emergency period.
- Suspension of Out-of-Network authorization requirements and pay these providers the Medicaid fee schedule.

Long-Term Services and Supports (LTSS)

- Remote services and telehealth are permitted for routine visits, level of care screenings, re-assessments, service plan development meetings, registered nurse supervisory visits, and service facilitator reassessment visits.
- Quality sampling requirements for waiver services are reduced due to limited provider capacity to complete files for quality management review desk audits.

Home and Community-based Settings (Appendix K)

Medicaid Memo 4/22/20

- Home and community-based settings are permitted to limit the number of visitors to their residences to minimize the spread of infection from COVID-19.

Coverage Protections for Members (Appendix K)

Medicaid Memo 4/22/20

- Members will retain waiver coverage even if they do not receive a service over a 30-day period.
  - For these members, MCOs will be reaching out monthly via telephone to do a safety check.
- Level of Care re-evaluations are extended from 12 months to 18 months.

LTSS Staffing Flexibilities (Appendix K)

Personal Care/Respite Services (effective 4/20/20)

Medicaid Memo 4/22/20

- Spouses, parents of minor children, and legal guardians can provide and be reimbursed for personal care services.
- Personal care, respite and companion aides employed by an agency can perform services prior to completion of the required 40 hours of training. Agency providers are required to ensure that aides:
  - Are proficient in the skills needed to care for Medicaid members prior to delivering services in the home.
  - Receive the required 40 hours of training within 90 days after they begin performing services.

LTSS Provider Sustainability (Appendix K)

Retainer Payments (effective 3/12/20 – 6/30/20)

Medicaid Memo 5/15/20

- Adult day health centers and day support providers that are closed and unable to perform services due to COVID-19 may be eligible for retainer payments from March 12, 2020 through June 30, 2020.

- Providers can submit individual claims with a modifier to receive a payment rate of 65%.

1135 Waiver

Access to Long-Term Services and Supports (effective 3/12/20)

Medicaid Memo 5/26/20

- Permit individuals who choose to move to a nursing facility directly from a hospital to be accepted without a long-term services and supports screening.
- The Pre-Admission Screening and Resident Review (PASSR), Level One and Level Two, must be conducted within 30 days of admission.
- Choice must still be documented.

1135 Waiver

Nursing Facilities

Medicaid Memo 5/26/20 (effective 3/12/20)

- Minimum Data Set (MDS) Assessments for new admissions may be completed in 30 days (instead of 14 days).
- Nursing facilities may temporarily employ individuals, who are not certified nurse aides, to perform the duties of a nurse aide for more than four months, on a full-time basis if they can demonstrate necessary skills and techniques.

1135 Waiver

LTSS Provider Flexibilities

Medicaid Memo 5/26/20

- Waive in-person supervision by a registered nurse every two weeks for Home Health and waive 14 day in-person supervision for hospice (telephonic supervision is encouraged).
- Home health agencies may perform certifications, initial assessments, and determine a patient's homebound status remotely by telephone or via video communication in lieu of a face-to-face visit.

1135 Waiver

Program for All-inclusive Care for the Elderly (PACE) Medicaid Memo 5/26/20 (effective 3/12/20)

- PACE sites may use remote technology and telehealth options (including telephone communication) as appropriate, to review or gather member information that would normally be provided as a face-to-face service.
- Member consent of participation must be documented and written signatures obtained within 45 days after the end of the emergency.
- DMAS Quality Management Reviews will be desk reviews only.

1135 Waiver

Durable Medical Equipment (DME)

Medicaid Memo 5/26/20

- DME providers may deliver up to a 1-month supply at a time.
- DMAS will allow National Coalition for Assistive and Rehab Technology (NCART) recommendations for remote protocol, for complex rehab equipment.
- Telehealth visits are allowed for therapy evaluations unless it is determined a face-to-face evaluation is warranted.
- Face-to-face requirement for authorization of durable medical equipment for specific codes are waived.
- DMAS will allow temporary coverage for short-term oxygen use for specified acute conditions.

1135 Waiver

Certificate of Medical Necessity (CMN)

Medicaid Memo 5/26/20

- Temporary extension of current CMNs until the end of the state of emergency.
- Temporary suspension of the requirement for a CMN for new orders (effective April 13, 2020).
- The DME provider must have a written, faxed, emailed or verbal order from the practitioner that includes the members name, item(s) being ordered and a diagnosis.

Nursing Facility (NF) Supplemental Payment

Governor's Budget Amendment (effective 3/12/20)

- Additional payment to nursing facilities of $20 per day for each Medicaid resident through the emergency period (Executive Order 51).

Civil Monetary Penalty Funding

Nursing Facility Funding

Medicaid Memo 5/19/20

- The 2020 procurement process for applications for Civil Monetary Penalty (CMP) Funds is on hold until the 2021 CMP Application Cycle.
- CMS has granted to the states the ability to approve requests that meet CMS parameters for use of CMP Reinvestment funds for communicative technology.
- Communicative technology devices of up to $3,000 per facility for residents to use for both social and telehealth visits can be authorized by DMAS (application deadline 5/27/20).

Electronic Visit Verification (EVV) Transition Period Extended

- Until September 1, 2020, DMAS will continue to pay EVV claims with regardless of the status of EVV data. Claims that do not fully comply with the EVV requirements will receive informational error codes.
- On September 1, 2020, these error codes will result in claim denials.
- Applies to services provided for fee-for-service, CCC Plus and Medallion 4.0

Behavioral Health & Addiction Recovery Treatment (ARTs) Provider Flexibilities

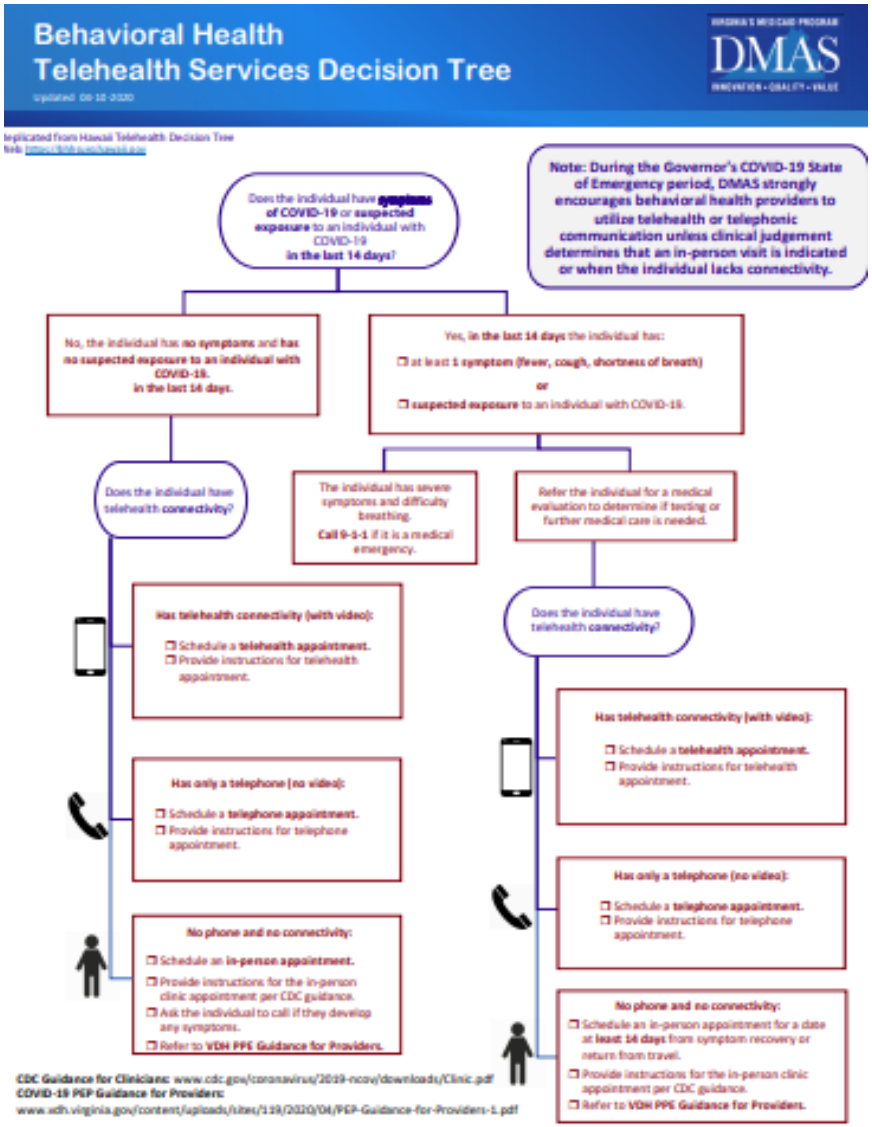
Behavioral Health Services

Medicaid Memo 3/27/2020

Enabling the delivery of various behavioral health services via telehealth or telephone, through trauma-informed care including:

- Crisis Response and Interventions;
- Care coordination, case management, and peer services;
- Service needs assessments (including the Comprehensive Needs Assessment and the IACCT assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities;
- Outpatient psychiatric services;
- Community mental health and rehabilitation services; and
- Addiction Recovery and Treatment Services (ARTS).

Behavioral Health Telehealth Decision Tree



Behavioral Health & Addiction Recovery Treatment (ARTS) Provider Flexibilities

ARTS Provider Flexibilities

Medicaid Memo 3/27/2020

- Opioid Treatment Programs (OTPs) can administer medication as take home dosages, up to a 28-day supply, to minimize exposure of COVID-19 to staff and patients.
- Reimbursement of the medication encounter for the total number of days' supplied of the take-home medication.
- Allowing the counseling component of Medication Assisted Treatment (MAT) to be completed via telehealth or telephone for patients suffering from substance use disorders.
- Preferred OBOTs or OTP's are not penalized for missed urine drug screens during the public health emergency.
- Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within Preferred OBOT or OTP.

Behavioral Health & ARTS Delivery of Services Flexibilities

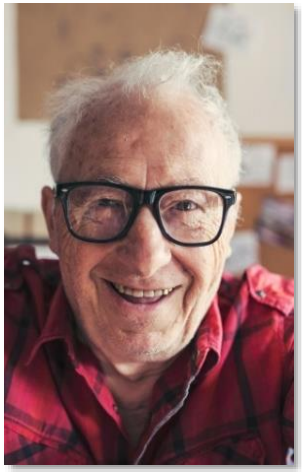
Authorizations and Licensure Reciprocity

Medicaid Memo 3/27/2020, Provider Webinar 4/22/2020

- Allowing up to 14 days after the start of a new behavioral health service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO or Magellan of Virginia.
- Individuals unable to be discharged from inpatient psychiatric care due to COVID-19, may continue to receive authorizations for a continued stay until they can be safely discharged into the community.
- Licensed Mental Health Professionals (LMHPs) licensed in another state may provide behavioral and substance abuse services to Virginia residents and receive reimbursement from DMAS. LMHPs with an active license issued by another state may be issued a temporary license by endorsement.







NON-COVID MANAGED CARE PROGRAMS UPDATE

CHERYL J. ROBERTS AND TAMMY WHITLOCK

Agenda

- Contracts
- Plan Changes
- MES
- Populations:
  - Maternity
  - Foster Care
  - New Dual-Eligibles – Default Enrollment

MCO Contract Changes

Contract Process

- DMAS has an MCO contract cycle
- A contracting team works with divisions and stakeholders to develop items for the contract and rates
- Those items are reviewed by DPB and a subset are included in the Governor's budget and reviewed by the General Assembly
- Once approved, the specific language is delved and internally reviewed, then submitted to DPB as a second check to ensure the language does not include contract changes that may impact the capitation rates or result in a material fiscal impact on the general fund, for which no legislative appropriation has been provided
- The contracts are then reviewed by OAG and CMS
- This year, the Governor asked DMAS to remove contract language that was approved in 2020 session due to budget concerns; therefore, this contract change list has been shortened

Impacts Both Programs

- Establishing payment targets for the total portion of medical spending covered under a value based payment arrangement
- Rewrite of contract section regarding Emergency and Post-Stabilization to reflect current operational practices
- Clarification on non-emergency transportation services and requirements
- Prohibition on MCO PBMs from spread-pricing
- Revise and add contract language related to Mergers and Acquisitions and significant operational changes
- Requirements to implement reimbursement reductions for readmissions and preventable emergency room visits
- General Alignment between contracts

MCO Contract Changes

Impact Medallion 4.0 Only

- Aligning terms and definitions to comport with the CCC Plus contract
- Re-arrange contract sections to improve readability
- Remove FAMIS language and place in an addendum to the contract
- Make changes in the FAMIS coverage addendum to comply with mental health parity
- Review and correct section reference errors in the body of the contract

Impacts CCC Plus Only

- Multiple revisions to complete moving CCC Plus contracting from renewing on CY to SFY
- Multiple revisions to naming of ongoing care coordination subpopulation groups (high-risk, moderate risk, etc.) and added clarification to clearly define subpopulation groups
- Clarify and correct MCO responsibilities with LTSS level of care review
- Allowing NF Staff to conduct LTSS level of care screenings
- Rate increase for personal care, respite and companion services (approved by the budget)

Plan Changes

VCU and Sentara

- VCU Health System and Sentara Health system have agreed that Sentara Health Systems will become the majority owner (80%) of Virginia Premier
- VCU Health System will retain a 20 percent ownership stake in Virginia Premier

Molina and Magellan

- On April 30, 2020, Molina entered into a definitive agreement to acquire the Magellan Complete Care ("MCC") line of business of Magellan Health, Inc.
- With the addition of MCC, Molina will serve more than 3.6 million members in government-sponsored healthcare programs in 18 states
- This transaction is expected to close in the first quarter of 2021

MES - The Next Two Modules

DXC – Provider Enrollment

- DMAS is currently working with DXC, who will be the future modular solution for Provider Enrollment Services and will meet the federal requirements for the Cures Act
- Provider Enrollment Services consists of screening, enrollment, provider web portal (secure), housing the provider files, and background checks for Fee For Service (FFS) providers in both Managed Care and FFS
- DMAS will also be implementing the federal requirements for the Cures Act that will create a unified CMS screening process for all providers

Care Management Solution (CRMS) Interface

- The new MES - CRMS system is designed to support the continuity of care of Medicaid members and will facilitate data exchanges when a member transitions between Fee-for-Service and Managed Care programs
- The modular system will serve as the database hub for service authorizations from all sources including FFS and Managed Care vendors and store service authorization records for all Virginia Medicaid and waiver services including medical, behavioral health and pharmacy services

Maternity

- The health of mothers and their children is essential to the mission of DMAS as DMAS delivers 39,000 newborns a year
- Governor Northam made it a top priority to end racial disparities that threaten the health of pregnant and postpartum women
- By 2025, we want all of our mothers and their babies to celebrate their child's first birthday together, healthy and happy
- The Healthy Birthday Virginia team is focusing on:
  - Targeted outreach on eligibility and delivery systems via Instagram, YouTube, and updated communications to provide education and information that will be helpful in improving services and outcomes
  - Disparities, care coordination, special conditions, targeted projects, state agency collaborations, and General Assembly initiatives

HAVING A BABY?

During your pregnancy, and even after your baby is born, we've got you covered.
Your coverage will remain active throughout the COVID-19 health emergency.

- Prenatal and postpartum care
- Emergency services
- Behavioral health services
- Increased access to telehealth
- 90-day supply of most prescriptions
- No copays
- Transportation services
- Dental care

For more information, visit https://coverva.org/covid19/

COVER VIRGINIA

DMAS

Foster Care

- Teams across DMAS along with our MCOs continue to work together to partner with DSS, Licensed Child Placement Agencies (LCPAs) and foster parents to support foster care youth
- Recent program highlights include:
  - Ensuring that when foster care members reach their 18th birthday while in foster care, they are automatically enrolled into another Medicaid benefit
  - Enhancing program reporting and data tracking in collaboration with our MCOs
  - Continuing our partnership with local social services offices and LCPAs on individual foster care cases
  - Promoting the YouTube video created for foster care workers on Medicaid coverage for youth in foster care
  - Continuing the annual DMAS Foster Care Focused Study
  - Highlighting local workers and MCO success stories in a May is Foster Care Awareness Month Newsletter

Foster Care Awareness Month

DMAS supports families and youth across the Commonwealth touched by the child welfare system.

COVER VIRGINIA

DMAS

Default Enrollment into Dual-Eligible Special Needs Plan (D-SNP)

- Previously known as Seamless Conversion – Default Enrollment allows a Health Plan to enroll a member of their Medicaid MCO into their D-SNP upon that member becoming eligible for Medicare
- Promotes the alignment and integration of Medicare-Medicaid, which evidence has shown leads to improved health outcomes and member satisfaction through reducing the burden of navigating two complex systems for both members and providers
- All six MCOs have received approval and are at various points of implementation.

Default Enrollment – Key Features

- Requires CMS and DMAS approval prior to implementation
- DMAS identifies the eligible members and sends each MCO a monthly file with their eligible members at least 90 days prior to the member's Medicare effective date
- DMAS sends a "90-day notice" to members explaining default enrollment, resources if they have questions and their rights. *(Not required but done as a best practice. DMAS worked with VICAP in development of this notice.)*
- MCO send a notice at least 60 days prior to the Medicare effective date ("60-day notice") informing the member that they will be default enrolled, resources if they have questions and their rights *(Notice was also developed in conjunction with VICAP.)*
- Member has the right to opt-out

Questions from committee members?

Public Comment

- Letter submitted by Conexus

Questions from the public or committee members

Resources

Topic	Email box
Commonwealth Coordinated Care Plus	cccplus@dmas.virginia.gov
Medallion 4.0	M4.0Inquiry@dmas.virginia.gov